SECTION 2:

CERTIFIED FAMILY NURSE PRACTITIONER

and

PEDIATRIC NURSE PRACTITIONER

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1 GENERAL POLICY

Services of a Certified Family Nurse Practitioner are provided to clients eligible for or receiving Medicaid. Services of a Pediatric Nurse Practitioner are available to children under age 21 who are eligible for or receiving Medicaid. The services are available to the extent that the family nurse practitioner or pediatric nurse practitioner is authorized to practice under state law or regulation at Utah Code Annotated Title 58-44a. (Authority: Social Security Act 1891(gg)) and 42 CFR 440.165.

1 - 1 Clients Enrolled in a Managed Care Plan

A Medicaid client enrolled in a managed health care plan, such as a health maintenance organization (HMO), must receive all health care services, including medical supplies, through that plan. Refer to SECTION 1 of this manual, Chapter 5, Verifying Eligibility, for information about how to verify a client's enrollment in a plan. For more information about managed health care plans, please refer to SECTION 1, Chapter 4, Managed Care Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

A list of HMOs with which Medicaid has a contract to provide health care services is included as an attachment to the provider manual. Please note that Medicaid staff make every effort to provide complete and accurate information on all inquiries as to a client's enrollment in a managed care plan. Because eligibility information as to what plan the patient must use is available to providers, a "fee for service" claim will not be paid even when information is given in error by Medicaid staff.

1 - 2 Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are *not* enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

1 - 3 Billing

Nurse practitioner (FNP or PNP) services may be billed electronically or on paper, using the CMS-1500 claim format. Instructions for completing a paper CMS-1500 claim form are included with this manual. See Section I, Chapter 11, or online at http://health.utah.gov/medicaid/pdfs/SECTION1.pdf .

The family or pediatric nurse practitioner bills through the collaborating physician. The nurse practitioner must have a working relationship and agreement with a collaborating physician for immediate referral of problem cases identified during the course of practice. Direct reimbursement is available as a payment option to the family or pediatric nurse practitioner practicing independently from a hospital, outpatient clinic, or physician office. The nurse practitioner will be paid at the fee schedule. Additional fees, such as site of service 22 hospital clinic fees, are not a covered Medicaid service.

1 - 4 Definitions

A Certified Family Nurse Practitioner is a registered professional nurse who:

- Is currently licensed to practice in the state as a registered professional nurse;
- Is legally authorized by the state or regulations to practice as a family nurse practitioner; and
- Has completed a program of study and clinical experience for family nurse practitioners, as specified by the state.

Family Nurse Practitioner services are services within the scope of practice authorized by state law for the family nurse to provide primary care services.

A Certified Pediatric Nurse Practitioner is a registered professional nurse who:

- Is currently licensed to practice in the state as a registered professional nurse;
- Is legally authorized by the state or regulations to practice as a pediatric nurse practitioner; and
- Has completed a program of study and clinical experience for pediatric nurse practitioners, as specified by the state.

Pediatric Nurse Practitioner services are services within the scope of practice authorized by state law for the pediatric nurse to provide primary care services for children.

2 LIMITATIONS

Certified Family Nurse Practitioners and Certified Pediatric Nurse Practitioners must work within their scope of licensure and in association with physicians to whom they refer patients with high risk conditions or complications.

A. Emergency only clients - services for labor and delivery
Only labor and delivery codes are billable for an individual with an Emergency Services only Medicaid Identification Card. Other maternity care services (prenatal and postpartum) are not payable for an emergency only client. For more information on the Emergency Services Program, refer to SECTION 1, General Information.

B. Procedures approved by Medicaid for coverage when delivered by a family nurse practitioner, or a pediatric nurse practitioner, are open for their provider type. Procedures completed outside of the procedures approved by Medicaid are not reimbursable. When a non-covered procedure (i.e. lumbar puncture) is provided by a nurse practitioner then billed through the collaborating physician, the bill is not considered appropriate. When program integrity identifies non-covered procedures billed through the physician, a refund will be required. Nurse practitioners who have been approved by the Department to perform a specific procedure, based on their training and certifications, are the only individuals who will receive reimbursement for these services.

C. Nurse practitioners working in federally designated Rural Health Clinics or Federally Qualified Health Centers function under the federal regulations governing services in such facilities.

D. Nurse practitioners employed as staff working in locally operated hospitals or clinics are not authorized to have their services separately billed.

E. Use of Checklists and Templates
Correct use of the Checklist in Evaluation and Management Documentation as outlined in Medicare Part B, June 2006, has been adapted for review of office visits. Keep the following important documentation guidelines in mind when using a template and/or checklist:

1. Examination templates and checklists are acceptable documentation provided the provider has clearly indicated what was examined and the findings to support the level of service billed.
2. A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings.
3. Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) must be described.
4. The provider must document and describe any specific and pertinent abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s). A notation of “abnormal” without elaboration is insufficient documentation. A key explaining checklist symbols must be available, if requested.
5. Signature requirements remain the same in the use of checklists. Per NCP PHYS-001, “an indication of a signature in some form needs to be present.” Documentation must support legible identification of the billing provider, per the 1995 or 1997 Evaluation and Management Documentation Guideline.
6. The Review of Systems (ROS) and Past Family Social History (PFSH) may be recorded by ancillary staff or completed by the patient, on a form or checklist. The checklist must have a place for the physician to document that he/she reviewed the information and make a notation supplementing or confirming the information recorded by others. If the ROS and/or PFSH are unchanged from an earlier encounter, it does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may be documented by noting the date and location of the earlier ROS and/or PFSH with a description of any new findings and/or a statement that all other elements are unchanged.
7. When referring to an earlier encounter to document the ROS and/or PFSH, all elements documented and performed in the earlier visit must be reviewed in the current visit. Any variation or elements not reviewed must be documented in the current note.

8. Only the provider can perform the History of Present Illness (HPI). The provider is ultimately responsible for submitting appropriate documentation. Each item on a checklist requires an active response for each exam component performed or question asked. It is not appropriate to use a common template which states that all components listed were performed unless otherwise noted by the practitioner.
9. In addition, there must be a written summary of the assessment, and a treatment plan. The primary components of the E&M service as outlined in the 1995 or 1997 E&M guideline must be clearly documented. For example, a template used for education is not a covered service. At the time of an audit the provider must stipulate which one of the E&M guidelines they are using.

F. Laboratory procedures

Laboratory services provided by a nurse practitioner in the office are limited to the waived tests or those laboratory tests identified by CMS for which each individual practitioner is CLIA certified to provide, bill, and receive Medicaid payment. Please note that most of the CLIA waived tests must be submitted with the QW modifier. (See CPT list of covered codes for nurse practitioners in this manual.)

Clinical diagnostic laboratory tests that are sent to an outside independent laboratory to be completed must be billed by the laboratory completing the service. The practitioner cannot bill for these services and seek payment from Medicaid.

– Urinalysis using a code like 81002 is incidental to an office visit and use of an appropriate E/M code.

– Pulse oxymetry (94760, 94761) is a non-invasive measurement of oxygen saturation which requires a minimal amount of time and is considered incidental to an E/M code or anesthesia administration. No additional payment will be made for this procedure.

G. A specimen collection fee is limited only to specimens drawn to be sent outside of the office for processing and only to specimens collected by one of the following methods:

- Drawing a blood sample through venipuncture, i.e., inserting a needle attached to a syringe into a vein and withdrawing a sample of blood. (Code 36415 is used to bill this fee.)

or

- Collecting a urine sample by catheterization.

Venipuncture is not a covered service when finger or heel sticks are done for a reagent strip test with codes like the following:

82948, blood glucose by reagent strip
83036 with QW modifier, glycated hemoglobin
85014 with QW modifier, hematocrit

None of these are venipuncture procedures. Therefore, code 36415 for venipuncture will be considered mutually exclusive to any of the CPT codes used for reagent strip testing. However, if other blood specimens are ordered which require venipuncture, 36415 payment will be allowed.

Obtaining a pap smear is limited to and included in the reimbursement for an office visit. A specimen collection fee is not separately billable for this service.

H. Finger/heel/ or ear sticks are limited only to infants under the age of two years by use of CPT Code 36416.

3 NON COVERED SERVICES

Medicaid does not cover certified family nurse practitioner (FNP) or pediatric nurse practitioner (PNP) services in the following situations:

Services not specifically defined under the Medicaid scope of service are not covered, even though in other settings, the family nurse practitioner or pediatric nurse practitioner may perform them.

1. Infertility diagnosis or therapy is not a covered Medicaid service.

2. Pre-pregnancy counseling is not a covered Medicaid service. It is not well defined and suggests prevention or education which are not general covered Medicaid services.

3. Pap smear is not a separate billable service, but is considered as part of an office call. The laboratory completing the service bills for the service.

4. Problems encountered during pregnancy must not be billed as separate services unless they are severe, unusual complications and require specific separate therapy which can be coded with a specific diagnosis code.

5. PMS is a very controversial diagnosis and is not considered a covered service for Medicaid.

6. Routine, preventive medicine type services are not covered for adults. All office calls must be for a specific, identifiable service in relation to a medical need which can be coded by an appropriate ICD-9-CM diagnosis code.

7. The services of an assistant surgeon are specialty medical services to be covered only by a licensed physician and only on very complex surgical procedures. A nurse practitioner is not authorized to function as an assistant surgeon or as assistants at surgery. The AS modifier, indicating the assistant surgeon is a PA or NP is not covered under Medicaid. It has always been Utah Medicaid policy that the modifier 80-assistant surgeon is payable strictly to a qualified surgeon. Physician assistants and nurse practitioners cannot be reimbursed as the assistant surgeon through the physician's provider number as an incident to service.

8. Routine physicals in adults.

9. Prolonged educational and counseling services, beyond those included within the initial evaluation and management service, are excluded as family planning services.

10. Office visits only for administration of medication.

11. Experimental, investigational, or cosmetic procedures.

12. With the exception of pre-post natal education provided under code S9445, separate sessions for education are not a covered benefit. Education may be provided within an evaluation and management service when there is an additional reason for the visit. Education and nutritional support programs for weight control are not a covered service.

4 COVERED SERVICES

Ambulatory, non-institutional type services directed toward management of health care for infants and children are covered services for the pediatric nurse practitioner. The family nurse practitioner may serve as a primary care provider for men, women, or children under their scope of practice and perform some limited inpatient services related to labor and delivery, if authorized in hospital policy. CPT codes will be used by the FNP and PNP to account for program utilization and to differentiate between nurse practitioner services and physician services. Editing will be done with the designated provider type. (See CPT list of covered codes for nurse practitioners in this manual.)

1. Cognitive services by a provider are limited to one service per client per day. When a second office visit for the same problem occurs on the same date as another service, the nurse practitioner must combine the services as one service and select a procedure code that indicates the overall care given.

2. Physical examinations are covered in the following circumstances:

   a. Preschool and school age children, including those who are EPSDT (CHEC) eligible, participating in the ongoing CHEC program. The Child Health Care and Exam recommended schedule is found in the CHEC Manual at http://health.utah.gov/medicaid/pdfs/appendices102004.pdf .

   b. New patients seeing a nurse practitioner for the first time with an initial complaint where a physical examination, including a medical and social history, is necessary.

   c. Medically necessary examinations associated with birth control medication, devices, and instructions for those of childbearing age, including sexually active minors.

3. After-hours office visit codes 99050 and 99058 may be used by a nurse practitioner who responds to treat an established patient in the office for a medical emergency, accident or injury after regular office hours. A group practice with established evening/weekend office hours, or a free-standing urgent care facility which operates as a physician office may be subject to correct coding initiative edits surrounding these codes. Only one of the after-hours office codes can be used per visit in addition to the E&M or service code.

   Limitations on use of the after-hours office visit codes include:
   a. They cannot be used in a hospital setting, including the Emergency Department, under any circumstances;
   b. They cannot be used for standby or waiting time for delivery or other similar situations;
   c. They cannot be used when seeing a new patient.

4. Consultation services are considered physician services and reimbursed only to the physician. Under incident to service in Utah Medicaid, the nurse practitioner may complete the history and examination to assist the physician in working the patient up for a consultant. The nurse practitioner must personally document in the medical record his/her portion of the consultation.

5. Incidental edits occur when a procedure is considered an integral component of another procedure. Diagnostic procedures performed along with larger, major therapeutic procedures are considered incidental to the major procedure, and no additional payment is warranted. Some codes which are considered minor procedures such as urine dipstick, removal of cerumen, and straight catheterization are included in the evaluation and management service as incidental to the service.

6. An injection code which covers the cost of the syringe, needle, and administration of the medication may be used with the injectable medication code, or J-Code (NDC), when medication administration is the only reason for an office call.

   Note: An office visit, J-Code (NDC), and an administration code cannot be used all for the same date of service. Only two of the three codes can be used at any one time or at any one visit.

7. A number of prenatal and postnatal educational sessions are covered under code S9446.

8. Rural services performed in rural areas will be reimbursed at 12% higher than the regular fee schedule. The higher fee is available only when the FNP or PNP practices or travels to the rural setting. Payment is not based on patient residence.

CPT List of Codes Covered for Family and Pediatric Nurse Practitioners

The following codes are open to the family and pediatric nurse practitioner provider type.

11975 INSERTION,IMPLANTABLE CONTRACEPTIVE CAPSULES
12001 SIMP REPAIR/SUPERFCL WNDS/SCLP,NK,EXTREMIT;2.5 CM<
12002 SIMP REPAIR/SUPER WNDS/SCLP,NK,EXTREMIT;2.6-7.5 CM
12004 SIMP REPAIR/SUP WNDS/SCLP,NK,EXTREMIT;7.6-12.5 CM
12005 SIMP REPAIR/SUP WNDS/SCLP,NK,EXTREMIT;12.6-20.0 CM
12006 SIMP REPAIR/SUP WNDS/SCLP,NK,EXTREMIT;20.1-30.0 CM
12007 SIMP REPAIR/SUP WNDS/SCLP,NK,EXTREMIT;OVER 30.0 CM
12011 SIMP/REPAIR/SUP WNDS/FACE,EAR,LIP,MUC MEM;2.5 CM<
12013 SIMP REPAIR/SUP WNDS/FACE,EAR,LIP,MUC MEM;2.6-5 CM
12014 SIMP REPAIR/SUP WNDS/FACE,EAR,MUC MEM;5.1-7.5 CM
12015 SIMP REPAIR/SUP WNDS/FACE,EAR,MUC MEM;7.6-12.5 CM
12016 SIMP REPAIR/SUP WNDS/FACE,EAR,MUC MEM;12.6-20 CM
12017 SIMP REPAIR/SUP WNDS/FACE,EAR,MUC MEM;20.1-30.0 CM
12018 SIMP/REPAIR/SUP WNDS/FACE,EAR,MUC MEM;OVER 30 CM
16000 BURN-INIT TREAT,1ST DEGREE,LOCAL ONLY
17110 DESTRUCT OF BEN LESIONS OTHER THAN SKIN TAGS CUTAN
36415 COLLECTION OF VENOUS BLOOD BY VENIPUNCTURE
36416 COLLECTION OF CAPILLARY BLOOD SPECIMEN
51701 INSERTION OF NON-DWELLING BLADDER CATHETER (I.E. STRAIGHT CATHETERIZATION)
57170 DIAPHRAGM/CERVICAL CAP FITTING WITH INSTRUCTIONS
58300 INSERTION OF INTRAUTERINE DEVICE (IUD)
81002 URINALYSIS DIPSTICK/TAB REAGENT, NON-AUTO, W/O MICRO
81025 URINE PREGNANCY TST BY VISUAL COLOR COMPARISON METHODS
82044 URINE MICROALBUMIN
83036 HEMOGLOBIN, GLYCOSYLATED (A1C)
82270 BLOOD OCCULT, PEROXIDASE, FECES
82948 BLOOD GLUCOSE, REAGENT STRIP
84478 TRICYLCERIDES
84703 GONADOTROPIN, CHORIONIC, QUALITATIVE
85018 HEMOBLOBIN (HGB)
85014 BLOOD COUNT; HEMATOCRIT (HCT)
85651 SEDIMENTATION RATE, ERYTHROCYTE; NONAUTOMATED
86580 SKIN TEST; TUBERCULOSIS, INTRADERMAL
87210 SMEAR, PRIM SOURCE, W INTERP; WET MOUNT INFECT
87804 INFLUENZA
87807 RESPIRATORY SYNCYTIAL VIRUS
87880 GROUP A STREPTOCOCCUS
90471 IMMUNIZATION ADMIN;SINGLE OR COMB VACCINE/TOXOID ***Use SL modifier - VFC program***
90472 IMMUNIZATION ADMIN;2+SINGLE/COMB VACCINE/TOXOIDS ***Use SL modifier - VFC program***
90632 HEPATITIS A VACC,ADULT DOSAGE,INTRAMUSCULAR USE
90633 HEPATITIS A VACC,PED/ADOLE DOSE-2 DOSE,INTRMUSCLR
90634 HEPATITIS A VACC,PED/ADOLE DOSE-3 DOSE,INTRMUSCLR
90636 HEPATITIS A/HEPATITIS B VACC,ADULT,INTRAMUSCULAR
90645 HEMOPHILUS INFLUENZA B VACC,(4 DOSE),INTRAMUSCULAR
90649 HUMAN PAPILLOMA VIRUS VACCINE,3 DOSE SCHEDULE,INTR
90657 INFLUENZA VIRUS VACC,SPLT VIR,6-35 MO,INTRAMUSCLR
90658 INFLUENZA VIRUS VACC,SPLT VIR,3 YRS+,INTRAMUSCLR
90669 PNEUMOCOCCAL CONJUG VACC,POLYVALENT,INTRAM,<5 YRS
90700 DIPHTHERIA,TETANUS TOXOIDS,(DTAP),INTRAMUSCULAR
90701 DIPHTHERIA,TETANUS TOXOIDS,(DTP),INTRAMUSCULAR
90702 DIPHTHERIA/TETANUS TOXOIDS ADSORBED PED USE,INTRA

90703 TETANUS TOXOID ABSORBED,FOR INTRAMUSCULAR USE
90704 MUMPS VIRUS VACCINE,LIVE,FOR SUBCUTANEOUS USE
90705 MEASLES VIRUS VACCINE,LIVE,FOR SUBCUTANEOUS USE
90706 RUBELLA VIRUS VACCINE,LIVE,FOR SUBCUTANEOUS USE
90707 MEASLES,MUMPS,RUBELLA VIRUS VACC,LIVE,SUBCUT/INJEC
90708 MEASLES & RUBELLA VIRUS VACCINE,LIVE,SUBCUTANEOUS
90710 MEASLES,MUMPS,RUBELLA, & (MMRV),LIVE,SUBCUTANEOUS
90712 POLIOVIRUS VACCINE,(ANY TYPE(S))(OPV),LIVE ORAL
90713 POLIOVIRUS VACCINE,INACTIVATED,(IPV),SUBCUTANEOUS
90714 TETANUS & DIPHTHERIA TOXOIDS PRESERVE FREE <7YRS
90715 TETANUS,DIPHTHERIA TOXOIDS PERTUSSIS VAC,>=7 YRS
90716 VARICELLA VIRUS VACCINE,LIVE,FOR SUBCUTANEOUS USE
90717 YELLOW FEVER VACCINE,LIVE,FOR SUBCUTANEOUS USE
90718 TETANUS/DIPHTHERIA ADSORBED 7+ YEARS,INTRAMUSCULAR
90719 DIPHTHERIA TOXOID, FOR INTRAMUSCULAR USE
90720 DIPHTHERIA,TETANUS,PERTUSSIS VACC,(DTP-HIB),INTRA
90721 DIPHTHERIA,TETANUS,PERTUSSIS VACC(DTAP-HIB),INTRA
90725 CHOLERA VACCINE FOR INJECTABLE USE
90727 PLAGUE VACCINE,FOR INTRAMUSCULAR USE
90732 PNEUMOCOCCAL POLYSACCHARIDE VACC,ADULT,SUBCUTAN
90733 MENINGOCOCCAL POLYSACCHARIDE VACC(ANY GROUP),SUBCU
90734 MENINGOCOCCAL CONJ VACCINE,(TETRAVALENT),INTRAMUSC
90735 JAPANESE ENCEPHALITIS VIRUS VACC,SUBCUTANEOUS
90744 HEPATITIS B VACCINE;PED PED/ADOLESCENT DOSE,INTRAM
90746 HEPATITIS B VACCINE,ADULT DOSAGE,INTRAMUSCULAR
90748 HEPATITIS B & (HIB) VACCINE,INTRAMUSCULAR
90772 THERAPEUTIC OR DIAGNOSTIC INJECTION, SUBQ or IM
96150 HEALTH & BEHAV ASSESS, EA 15 MIN FACE-TO-FACE,INIT
96151 HEALTH & BEHAVIOR ASSESSMNT,EA 15 MIN;REASSESSMENT
96152 HEALTH & BEHAV INTERVENTION,EA 15 MIN,INDIVIDUAL
96153 HEALTH & BEHAV INTERVENTION,EA 15 MIN, GROUP
96154 HEALTH & BEHAV INTERVENTN,EA 15 MIN,FAMILY W/PATNT
96155 HEALTH & BEHAV INTERVENTN,EA 15 MIN,FAMILY W/O PAT
99050 SERVICES AFTER HOURS IN ADDITION TO BASIC SERVICES
99058 OFFICE SERVICES PROVIDED ON AN EMERGENCY BASIS
99080 SPECIAL REPORTS(EG INS,MED DATA)OVER USUAL COMMUN
99170 ANOGENITAL EXAM W COLPOSCOPIC MAGNIF CHILD TRAUMA ***This code is open only to Nurse Practitioners working with the Criminal Justice system who have completed special training to complete the procedure on children***
99201 OFFICE / OUTPAT VISIT NEW 3/3 H:PF E:PF D:SF
99202 OFFICE / OUTPAT VISIT NEW 3/3 H:EP E:EP D:SF
99203 OFFICE / OUTPAT VISIT NEW 3/3 H:DT E:DT D:LC
99204 OFFICE / OUTPAT VISIT NEW 3/3 H:CM E:CM D:MC
99205 OFFICE / OUTPAT VISIT NEW 3/3 H:CM E:CM D:HC
99211 OFFICE / OUTPAT VISIT E/M EST MAY NOT REQUIRE PHYSICIA
99212 OFFICE / OUTPAT VISIT ESTAB. 2/3 H:PF E:PF D:SF
99213 OFFICE / OUTPAT VISIT ESTAB. 2/3 H:EP E:EP D:LC
99214 OFFICE / OUTPAT VISIT ESTAB. 2/3 H:DT E:DT D:MC
99215 OFFICE / OUTPAT VISIT ESTAB. 2/3 H:CM E:CM D:HC
99381 INIT E&M HEALTHY INDIVD, NEW PT,(AGE UNDER 1 YEAR)
99382 INIT E&M HEALTHY INDIVID,EARLY CHILDHOOD(AGE 1-4)
99383 INIT E&M HEALTHY INDIVID,LATE CHILDHOOD(AGE 5-11)
99384 INIT E&M HEALTHY INDIVIDUAL,ADOLESCENT(AGE 12-17)
99385 INITIAL E&M OF HEALTHY INDIVIDUAL 18-39 YEARS
99391 PERIODIC REEVAL&MGMT,HEALTHY INDIV AGE UNDER 1YR
99392 PERIODIC REEVAL & MGMT HEALTHY INDIVIDUAL(AGE 1-4)
99393 PERIODIC REEVAL & MGMT HEALTHLY INDIVID(AGE 5-11)
99394 PERIODIC REEVAL & MGMT HEALTHY INDIVID(AGE 12-17)
99395 PERIODIC REEVAL & MGMT HEALTHY INDIVID(18-39 YRS)
99432 NORM NB CARE(OTHER THAN HOSP/BIRTH RM)PE,CONFERENC
H1000 PRENATAL CARE, AT-RISK ASSESSMENT
H1001 PRENATAL CARE, AT-RISK ENHANCED; ANTEPARTUM MGMT

J0585 BOTULINUM TOXIN TYPE A, PER UNIT
J0696 INJECTION, CEFTRIAXONE SODIUM, PER 250 MG
J1055 INJ,MEDROXYPROGESTERONE ACETATE,CONTRACEPT 150 MG
J1100 INJECTION,DEXAMETHASONE SODIUM PHOSPHATE, 1 MG
J7030 INFUSION, NORMAL SALINE SOLUTION, 1,000 CC
J7300 INTRAUTERINE COPPER CONTRACEPTIVE
J7302 LEVONORGESTREL-RELEASING IU CONTRACEPTIVE, 52 MG
S9446 PATIENT EDUCATION,NOC,NON-MD PROVDR,GROUP,PER SESSION
This code is open for pre-postnatal education for females 10-55 years of age–Limited to 8 within 12 months
S9981 MEDICAL RECORDS COPYING FEE, ADMINISTRATIVE
T1015 CLINIC VISIT/ENCOUNTER, ALL-INCLUSIVE (used in rural health centers)

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